The Bulletin
OF THE
South Indian Medical Union.

Vol. III. | MAY 1931. | No. 5.

COMMEMARAT... 11 JUN 1931 MADRAS

CONTENTS.

		Page.
1.	(a) General Notes ...	3
	(b) Honorary Medical Appointments Committee ...	5
	(c) The All India Medical Conference, 1931 ...	7
2.	Unions: South Indian Medical Union, Madras.	
	(a) Report 1930-31 ...	9
	(b) Annual Meeting, 1931.	14
3.	Modern Technique in the Treatment of Pulmonary Tuberculosis. By Dr. S. Krishnaswamy, M.B., B.S. ...	15
4.	The Successful Medical Practitioner. By Dr. U. D. Gopal Rao.	25
5.	Review ...	32

PUBLICITY SECTION.

NOTICE.

1. The Union does not accept any responsibility for the views and statements of the contributors as published in the Bulletin; all manuscripts, books, drugs, and other appliances for review and letters intended for publication must bear the name and address of the author, not necessarily for publication.

2. Copy, cuts and blocks for advertisement should reach this Office at least before the 15th of the month of issue. Advertising rates will be supplied on application. Every effort will be made to accommodate advertisers' request for suitable space, position and proper display of advertisements but particular positions cannot be guaranteed. All advertisements are accepted subject to the above.

3. Remittances should be made by crossed cheques, registered letter or money order, payable to the *Publicity Section*, South Indian Medical Union.

4. Medical Students and those *interested* in Medical Relief will be placed on the complimentary mailing list of the BULLETIN on application to the Publicity Section.

Address all communications for :—

(1) Publicity Section—51, Poonamallee Road, Kilpauk, Madras.

(2) General Section—100, Poonamallee Road, Vepery, Madras.

"PEOPLE IN BUTTONS"

Gilbert K. Chesterton has turned another witty phrase. This one was to the benefit of the medical profession, and every perspiring doctor, trying hard to convey in words just what a medical bureaucracy might mean, will surely thank him.

Mr. Chesterton is reported to have said in Chicago, the other day: "The panel system of medical practice or its allied systems is merely delegation of the practice of medicine to a GROUP OF PEOPLE IN BUTTONS."

That is, of course, what every champion of private medical practice has been feeling and attempting to say about State Medicine ever since that bogie first raised a menacing head in the American social picture. Mr. Chesterton said it in a word.

"I am against people in buttons interfering with the rights of any man," said the famous English philosopher and satirist, expanding his remark in an interview on the British medical situation which should interest every American medical man.

The theory of the rational modern state is against bureaucracy. The dole is a tragic thing. So is any measure that metes out a perpetual interference with individual rights and free contacts of the citizenry. Which is exactly what the panel system does. It removes from one class of people the right to make free contacts for individual necessities.

"It is an evil thing when you classify and codify and put into a system of law a recognition of employers and employees as variant classes to be so shown under any constitution. It is an evil thing to deprive the poor of the privilege of choice and to make for them a sort of serfdom."

MINNESOTA MEDICINE.

BULLETIN

OF THE

SOUTH INDIAN MEDICAL UNION

MAY 1931.

GENERAL NOTES.

The name of the Union has been changed into the South Indian Medical Association. There has been a feeling that the word 'Union' savours of trade unionism which is undesirable in an association of members of a noble profession. We trust that the spirit of Union which pervades among the members will still continue and that the new change will enable other organisations holding the same views to affiliate or incorporate with us.

* * *

There are a number of medical associations in the Presidency. We invite them to send us their proceedings, etc., for publication and assure them of the hospitality of our columns.

* * *

We have received a copy of a memorial from some Karur practitioners to the Surgeon-General about the doings of the local assistant surgeon. We have all along been aware of the abuse of the hospitals and the consequent repercussion on the growth of the Independent Medical Profession and if things are as they have been represented to be, a more glaring example is hard to find. We understand that the local *service* incumbent has been granted study leave and hope that the relations between his successor and the private practitioners will be happier.

* * *

Speaking of study leave and the facilities given to members of the provincial services it might be interesting to know how members of the Independent Medical Profession are treated. It is a principle of the honorary system that appointments are individual and local. But we have here a rule that they are liable to transfer, and when it comes to *leave*, the Government in its wisdom has laid down that leave may be granted if

arrangements could be made locally involving no expenditure to the State, and as the honoraries are not allowed to provide their substitutes it is left to the kindness of his service colleague to oblige him and thus enable him to get leave.

* * *

But when he wishes to take long leave and proceed *at his own expense* for post-graduate studies he has, we hear, to resign his appointment. With the talk of expansion of the honorary system and also the cry for better qualifications from them, this step-motherly attitude is not understandable unless it be that machinations by interested parties have been at work. We trust that this among others will be considered by the Honorary Appointments Committee.

* * *

We understand that official heads have been invited to submit memoranda on retrenchment in their own departments. We wish that public bodies be also invited to do the same. There is one department, at least, in the Presidency where the axe could be used unsparingly. We mean the medical department. A drastic reduction in the cadre, increase in the hours of work, replacement of the paid service by honorary workers are all within the sphere of practical politics. We invite the views of the members of the medical profession on this matter.

* * *

We are glad to find that the general proceedings of the Annual Medical Conference at Poona held under the auspices of the Indian Medical Association has been more in consonance with the spirit of the times and the policy professed by the association. There is a strong movement to incorporate all the medical associations within the Indian Medical Association. Whilst we still hold that under existing circumstances it is undesirable to have a common membership of varying and conflicting interests in an association which is not purely scientific and which takes part in medical politics, we feel that it might be possible to come to a common understanding with such bodies on purely central subjects. The tendency nowadays is for provincial autonomy. As such, if local independence is guaranteed and the new orientation that has been shown in the recent proceedings is maintained it might be desirable if conversations are begun for a limited affiliation with a central body like the Indian Medical Association. We would like to have the views of the Profession in this Presidency.

Honorary Medical Appointments Committee.

What was rumoured some months ago has happened. We find from the local newspapers that the Government has finally decided to appoint a committee of medical men to advise them on matters relating to the honorary staff of the State hospitals and that they have decided on the terms of reference. We are still ignorant of what these terms are. The personnel of the committee is published. We consider it a serious omission that the Government has not thought it fit to nominate at least a few prominent lay public men to the committee. The efficient and adequate staffing of hospitals vitally concerns the public. The lay citizen is likely to have a shrewder knowledge of the defects of the present system. Further the educated and influential public come into more frequent and intimate association with the large body of men and women, who practise the profession outside the hospitals and Government dispensaries, and they are therefore in a position to more correctly assess the result of medical education as exhibited by the various classes of practitioners. The veiws of the public should therefore be respectfully listened to and their opinion carefully considered before deciding on any measures to extend the honorary scheme. It would have been well, therefore, if at least a couple of the people's representatives in the Legislative Council had been included.

On the other hand, we are puzzled to know what part the service members are expected to play on the Committee. Our friends suggest various explanations. One is that they are there with a watching brief on behalf of service interests. This is quite probable as we understand that one of the members of the Committee, the President of the Provincial Service Association, has already sent a questionnaire inviting the views of the members of his service. We fail to understand how the existence or extension of the honorary scheme could affect their *legitimate* interests, whatever they be. Their tenure is safe and so is their pay. At worst, if the scheme is extended some of these officers may be transferred to other areas or other fields of medical relief. This would not be an innovation. It is an everyday occurrence, as a part of the contract of service, where public need and exigencies control the posting of the members of service. It is also suggested that as Superintendents of hospitals when the increasing number of honoraries would work in the future, it would be useful to have their guidance in designing a scheme of this nature. This suggestion presumes that the present system of hospital administration would continue for ever. It is our view that this system has long outlived its usefulness and we are not prophesying when we say that other and better methods of hospital organisation would be introduced in the very near future. Apart from this, it is now common knowledge that paid men specially of the *provincial* service have been almost unanimous in opposing the advent of this scheme. Many of them have raised various difficulties in the way of the honorary officers discharging their duties in the different hospitals. Latterly due to causes outside of their control, these people have resigned themselves to be lukewarm. These officers seem to be obsessed with the fear that the honorary scheme is bound to undermine their prestige and cut their monopoly of practice. It is therefore unnatural to expect them to come forward with helpful suggestions towards the easy and efficient working of the honorary scheme. Whatever the terms of reference be, the Committee should concern itself with (1) the existing difficulties and defects in the honorary system, (2) the principles to be followed in future recruitment and

(3) if the scheme is to be permanent and to expand rapidly, what should be the privileges of the honorary officers and what facilities should be provided them for the efficient discharge of their duties.

When the scheme was incepted some years ago, seven of them were appointed to the various state hospitals in the city. Each was provided with what was termed "Rules for the guidance of the honorary officers". These rules were very simple and did not say much. Each hospital managed its affairs in its own way almost as if these rules did not exist. Some hospitals welcomed the honoraries, others managed with them as if nothing unusual had happened, some tolerated them and a few others received them in a way which left no doubt in the minds of the honoraries that they were not wanted there. Probably the vagueness of the rules was all to the good. For under such conditions the honorary system stood its ground. This success is due to the enthusiasm of the late Raja of Panagal and the sympathy of Major-General Sir Henry Symons and at least to an even measure to the first band of men who were appointed. We take our hats off to them In spite of the well-meant dissuasion of the elders, the indifference of the younger ones and the scarcely suppressed sneers of the vast majority of their friends in service, these new honoraries ventured on their duty as lone mariners on uncharted seas and with admirable patience and praiseworthy skill went on their course steering clear of the many sandbanks and more formidable reefs. The steady success which they showed even in the early part of their hospital career evidently carried confusion and consternation to those who were from the beginning suspicious of this new venture. The evil forces met, conspired and concieved plans to wreck the scheme. Fortunately for the country those in charge of the high direction of the department were able to see a little beyond the immediate present and thus saved the scheme. The successive surgeon generals have been impressed with the usefulness and possibilities of the honorary scheme as an essential factor in the expansion of medical relief in the presidency and it is no secret that the present surgeon-general is its enthusiastic supporter and is heartily encouraged by the Minister in charge of public health, himself an intimate friend and chela of the late Raja of Panagal.

We have briefly referred to the beginnings of the scheme and the obstacles thrown in its way, to show that the simple rules which were sufficient then cannot be considered adequate when the scheme is expanded and a larger number of medical men are taken on the staff of the various city and mofussil hospitals. We are, therefore, glad to find that there are on the Committee two members who have been continuously connected with the scheme since its inception and who more than any others should be well fitted to guide the Committee on the defects and difficulties of the original rules.

As to the principles to be followed in the recruitment we do not foresee much difficulty. The Union had submitted a scheme some time back. We understand that other bodies have also sent their views to the authorities. The personnel of the Committee makes us feel confident that they will formulate a scheme which is acceptable and at the same time practicable. But when it comes to other points that will have to be considered along with this, especially as regards the facilities for further progress and expansion, we are not so sanguine. If the scheme is to grow, if a larger number of men are required to give of their services to

the State it is only natural that they should consider the benefit of the State and also their individual benefit especially when it does not involve any loss to the State. We sincerely hope that the members of the Committee would spare no efforts to investigate the various methods that would be helpful to broadbase and build up the scheme. It behoves the large number of medical men scattered about the presidency to help the Committee with their suggestions. The BULLETIN will be very happy to recieve them and give them the necessary publicity and consideration.

The All-India Medical Conference, 1931.

By Dr. M. Sanjiva Rao, M.B., B.S., *Madras.*

The seventh annual session of the All-India Medical Conference was held at Poona, from the 25th to 27th April 1931, under the auspices of the Indian Medical Association with Dr. N. Jivraj Mehta, Dean of King Edward Memorial Hospital, Bombay, as President. It was a truly representative assembly of medical men from all over India, and the subjects discussed at the conference, covered practically the entire field of the Indian medical problem confronting us to-day. The first impression left on one's mind after the conference is the imperative need for an All-India organisation to ensure for the future a sane medical policy, incorporating

1. An even and efficient system of Medical relief, both rural and urban, throughout the length and breadth of India.

2. A system of Public medical service both civil and military, free from any clashing sectional interests, perpetuating discontent and demoralising the profession.

3. A liberal and reasonably cheap education, both collegiate and post-graduate, theoretical as well as intensely practical, to equip and maintain a high standard of professional efficiency.

4. Encouragement of the Honorary system, not only for financial considerations, but also to harness a much larger number of medical men to the immense amount of clinical material available in our country, and prevent its being literally wasted as at present.

Such aims as these which form the basis of our conception of Medical Swaraj, can only be achieved *in toto* through an efficient All-India organisation, especially when vested interests are fighting tooth and nail to perpetuate their domination, regardless of reason or logic. Speaking in this connection, the President observed, "I take it there will be no difference of opinion, when I say that an organisation of an All-India nature is very very essential not only to safeguard the interests of the profession as a whole, but also to enable the profession to give that advice and assistance to the State and people, in the solution of problems concerning sanitation, medical relief, medical research and education, medical services or social legislation, which a nation has the right to expect from members of the medical profession. No doubt there are several active local or provincial medical associations throughout the country, some of whom have played no mean part in developing public opinion on such matters. In the reorganisation of the whole country which is now in the air, we shall however fail to take our proper place if we did not, in the first instance, organise ourselves into an effective All-India body. Whether the constitution of our organisation should be, to borrow the current phraseology, Central or Federal, is to me a matter of detail. But let us not fritter away our energies

in multiplying a number of bodies supposedly of an All-India nature. In union lies our strength. You will moreover agree with me that it would not be possible to depend for all this work entirely on voluntary workers. These workers have so far done splendidly, but vested interests are so well organised that unless we have some paid agency to help our voluntary workers, it would not be possible for us to achieve all that we aim at. We must take a leaf from our antagonist's book, and set up a well managed and efficient Central Office. For all this it would be necessary for each and every one of us, to dip our hands into our pockets and help the cause according to our individual means . . . . . The way may be long and the fight may be grim while it lasts. But the end is certain to be a victory for the cause of justice and reason. The medical profession is perhaps the noblest avocation a man might take up. Our present Rulers are turning it into a nursery of parasites through the insatiate greed of the organised Service, to turn the most selfless posts into the most fruitful preying ground. Our fight is against this rooted parasitism; our ambition is to make the healer, as he was intended to be, a blessing to mankind, not a curse nor a self seeking institution. Who can doubt where the victory will eventually be?"

Medical Education.—One of the first important items on which there was complete unanimity of opinion was with regard to the future medical education. Whatever reason there might have been in the past, for the maintenance of medical schools with the four years course, as the minimum standard of medical education, the time has now come for a thorough overhauling of these institutions, both from the general as well as the medical educational aspects, and raising the minimum standard to conform to the recent advances in modern medicine and surgery. It is inconceivable how any one who is in the know of the rapid evolution of every branch of our science can oppose the raising of the minimum standard unless due to selfish interest to maintain for themselves a class of "*Feeders*" in addition to their own subordinates in service. We must confess that medical education in India whether scholastic, collegiate or post-graduate has all along been neglected and subjected to the exigencies of the paid services and their lucrative private practice and at the most has been purely theoretical. Though year after year large number of medical men, licentiates and graduates are turned out entitled to practise medicine and surgery, it is a well-known fact that few private practitioners have any surgical practice worth mentioning unless they be retired ex-service men or the few rich who have the means to go to foreign countries for post-graduate education. The large number of independent medical practitioners can ill-afford such foreign education and are denied all contact with premier hospitals and often have to be content to be feeders to superior services who have made surgery their monopoly. The one reason put forward in favour of restriction of the period of instruction of licentiates to four years is that in the interest of rural medical relief it is essential to turn out as many licentiates as possible. Dr. J. N. Mehta quoted statistics to prove that out of two thousand ninety-five licentiates who passed out from the College of Physicians and Surgeons (Bombay) since 1913 as many as one thousand twenty-eight have settled down in big cities or towns of population of more than 25,000. Experience of the licentiates of Madras cannot be very different either, so that the plea of expanding the medical relief in rural areas cannot hold water.

Medical Services.—The conference was unanimously of opinion that the

present system of Indian medical service as well as provincial and subordinate services require thorough overhauling. Regarding the I.M.S. it must remain an entirely Military service with the Civil side entirely lopped off. According to Col. Bhola Nath "such a combination of civil and military duties which subordinates the needs of civil population to the requirements of the military is unheard of in any other civilised country in the world." The recruitment to this service in future should be by open competitive examination from candidates holding qualifications registrable in India. "In view of the fact that about 500 to 600 medical graduates are being turned out every year from Indian Universities, and in view of the increased facilities which are now available for holding resident medical appointments in teaching hospitals, an ample supply of suitable candidates for the competitive examination for recruitment to the service is assured. With the introduction of competitive examination, various medical colleges and hospitals will vie with one another in providing special instructions for entrants into the examinations, an arrangement which will also help in encouraging the development of post-graduate medical instruction in India. May I add here that it has become highly necessary to institute an Army Medical College in India for the subsequent training of Army Medical Officers in this country on the lines more or less similar to those followed in other countries? As to the questions of granting commissions in Indian medical service and of the training of Military medical officers fall within the jurisdiction of the Military Department it is highly essential that a representative of the Indian Medical Association is appointed on Sandhurst Committee for training of military which as recently announced is shortly going to be constituted. As regards the provincial and subordinate medical services the time has now arrived to cease altogether recruiting officers for the Civil medical services excepting in services like the Public Health Service, the School Medical Service, etc., which should be manned by adequately paid medical officers with no right of private practice. The honorary system of work in Civil hospitals and dispensaries should be encouraged more and more and steps should be taken to expand rural medical relief by giving gratuities to medical men who settle down in rural areas. This latter is not so easy a problem as it looks but with some more thought given to its consideration it would not be impossible to devise some workable arrangements in this matter.

Association Notes.

SOUTH INDIAN MEDICAL UNION, MADRAS.

The Report of the working of the Union for the year ending March 1931.

The membership has considerably increased and it is most gratifying to note the increasing number of applications for membership from professional brethren in the mofussil.

The Financial statement as certified by the auditor is herewith appended.

Work.—We are very glad to note the increasing interest which the members take in the Union as evidenced by the number of papers read by the members before the Union.

The attendance of members at the clinical meetings was also very good.

1. The work ahead of us, Dr. M. Vijiaraghavalu, 14th July 1930.

2. The Role of general practitioners in a maternity clinic, Dr. A. Lakshmanaswamy Mudaliar, 18th August 1930.

3. Some common skin diseases, Lt.-Col. J. M. Skinner, I.M.S., 25th August 1930.

4. Radium in cancer, Lt.-Col. E. W. C. Bradfield, I.M.S., 15th September 1930.

Manufacture of Radium and Preservation of the same, Capt. T. Barnard, Radiologist, General Hospital.

5. Some corneal affections, Dr. E. V. Srinivasan, 29th September 1930.

6. Deafness, Dr. M. Sanjiva Rao, 20th October 1930.

7. Diagnosis of obscure fever, Lt.-Col. G. E. Malcomson, I. M. S., 27th October 1930.

8. Asthma, an adrenal insufficiency syndrome, Dr. M. Sriramulu, L.M.P., L.C.P.S., 17th November 1930.

9. Carbuncles, Dr. C. R. Krishnaswami, 24th November 1930.

10. The scientific aspect of the Tridosha theory, Dr. A. Lakshmipathi, B.A., M.B., C.M., 15th December 1930.

11. The successful practitioner, Dr. U. D. Gopal Rao, 29th December, 1930.

12. X-Ray examination of the gastro-intestinal tract, Dr. P. Rama Rao, 12th January 1931.

13. Dysenteries, Dr. T. Satakopan, M.D., 26th January 1931.

14. Diagnosis and treatment of some of the common affections of the Rectum, Dr. P. Govinda Rao, 9th February, 1931.

15. Ultraviolet Rays, Dr. R. C. Sudarsanam, 23rd February 1931.

16. Focal infections in Oto-rhino-laryngology, Dr. M. Sanjiva Rao, 9th March 1931.

17. On certain drugs used in heart cases, Dr. T. Krishna Menon, 23rd March 1931.

All the clinical as well as also the Governing Body Meetings were held at Dr. E. V. Srinivasan's Surgery in Broadway, and we cannot sufficiently thank him for his generosity in allowing us the use of his premises even at some inconvenience to him.

The Union is greatly thankful to the various gentlemen who have come forward to help us with their valuable contributions and we hope that all of them and others who are still a little shy would continue to instruct us from time to time in future with their lectures and papers.

General Meetings.—Three meetings were held during the year.

Governing Body Meetings.—Nine Governing Body meetings were held during the year. These meetings have been, as usual, well attended. We wish to take this opportunity of thanking the members of the Governing Body for the helpful instruction and guidance which they have ungrudgingly given us.

The Honoraries Committee met three times during the year and discussed the various questions relating to them in its present working and have drawn up a scheme embodying the various suggestions to improve its scope and facilitate its working.

Social.—In pursuance of the resolution passed by the Governing Body, the Union held a social on the 2nd of February at Khusaldoss Gardens to mark their appreciation of the invaluable services rendered by Dr. T. Krishna Menon, the previous Secretary, in furthering the interests of the South Indian Medical Union and to felicitate him on the conferment of the Kaiser I Hind Medal (second class) in the new year honours. Most of the city members of the Union and many distinguished visitors were present. The response of the members, when the donation list went round, was so generous that a sum of Rs. 61,

DEAR DOCTOR,

YOUR SKILL BECOMES OF NO AVAIL
IF NOT BACKED BY RELIABLE DISPENSING.

FOR

CORRECT DISPENSING
STANDARDISED DRUGS
PURE CHEMICALS
POTENT BIOLOGICAL PRODUCTS
PRESERVED IN *FRIGIDAIRE*

} WHOLESALE & RETAIL.

APPAH & CO.,

286, CHINA BAZAAR ROAD,

GEORGE TOWN, MADRAS.

Let Us Install

UP-TO-DATE SANITARY FITTINGS

TO

YOUR OFFICE AND HOSPITAL

Consultations and Estimate Free.

LAKSHMI RATANS LIMITED.

316, THAMBU CHETTY STREET, MADRAS.

Stop the Great Recurring Drain on Man Power of the Land.

INOCULATION PREVENTS and "HEDAURIN" cures and prevents CHOLERA.

Yet 26,000 die every year in the Presidency from CHOLERA !!

TRADE HEDAURIN MARK
ORIGINAL P.R.I.
DYSENTERY AND CHOLERA CURE

(*Extract of Hedyotis Auricularia.*)

Cures CHOLERA by simple oral administration.

GIVE IT A TRIAL AND SAVE THE INDIAN PEASANT.

As. 15. HEDAURIN As. 15.
SAVES A LIFE.

HEDAURIN is highly efficacious and Second to NONE in the treatment of **Colitis, Amoebic Dysentery,** acute or chronic, IDEAL in the treatment of allied bowel complaints of **Infants and Children.**

Available in Sizes :

As. 15, Rs. 1-12, Rs. 3-4 and Rs. 12-8.

CHILD WELFARE.

EVERY CHILD SAVED ADDS TO THE STRENGTH OF THE FUTURE NATION.

TRADE CIROBIL MARK
P.R.I.

(*Confectio Hedyotis Auricularia.*)

Specific for ENLARGEMENTS OF THE LIVER **of** CHILDREN.

Cures in TWENTY-ONE **days.**

Confirmed by Medical opinion.

Available in two sizes :

Rs. 3 and Rs. 5 only.

Can be had from all Chemists thoroughout Southern India.

Literatures on request from :

DADHA & CO., MADRAS.

Sole Distributors for India, Burma, Ceylon & Federated Malay States.

Statement of receipts and payments for the year ending 31st March 1931.

RECEIPTS.	Rs. A. P.	Rs. A. P.
To Balance as on 31-3-1930:		
With the Indian Bank Ltd.:		
Current Account ...	129 4 9	
Savings Bank Deposit ...	1,650 14 1	
Cash on hand ...	64 7 3	
		1,844 10 1
,, Subscriptions ...		1,091 8 0
,, Interest on Savings Bank Deposits ...		75 0 7
,, Donation re: entertainment ...		61 0 0
,, Bulletin Account:		
Collections ...	1,624 2 0	
Less payments ...	1,537 8 6	
		86 9 6
Total ...		3,158 12 2

PAYMENTS.	Rs. A. P.	Rs. A. P.
By Establishment ...		307 8 0
,, Printing and Stationery ...		116 15 9
,, Postage ...		21 4 0
,, General charges ...		38 10 6
,, Entertainment expenses ...		40 10 0
,, Balance:		
With the Indian Bank Ltd.:		
Current Account ...	899 2 9	
Savings Bank Deposits ...	1,725 14 8	
Cash on hand ...	8 10 6	
		2,633 11 11
Total ...		3,158 12 2

5, ERRABALU CHETTY STREET,
Madras, 4th May 1931.

Examined and found correct.
K. GOPALAKRISHNA RAO,
Government Diplomaed Accountant, Auditor.

P. RAMA RAO,
C. R. KRISHNASWAMI,
Secretaries.

which was the surplus after meeting all the expenses, was added to the general fund.

The Secretaries have great pleasure in reporting an all round progress in the activities of the Union and reporting the great interest and the ready co-operation of the members of the Committee on their work.

Bulletin.—The Bulletin, the official organ of the Union, has been increasing in its circulation and usefulness to the profession and the public and we are glad to hear that the appreciation which it has won in various quarters has helped to enhance the prestige of the Union in their eyes.

It is also gratifying to note that the Bulletin is becoming more and more self-supporting and we fervently hope that it will carry on its allotted task for years to come with advantage to the profession and benefit to the public.

The Union offers its sincere and heart-felt thanks to the various members of the Publicity Section who have uncomplainingly given of their time and energy towards the efficient conduct of the Bulletin.

We feel that the growing influence of the Union would help to enlist more members and with the continuance of the steady progress we have been maintaining all along, we will in course of time attain to that place in the body-politic which is ours by right.

Annual Meeting—1931.

The annual meeting of the South Indian Medical Union was held at 32, Broadway, Madras, on 11th May 1931 at 5-30 p.m. About 50 members were present and since this was purely a business meeting there were no visitors.

After a preliminary tea and a pleasant conversazione, the regular meeting of the evening began at 6-30 p.m. In the unavoidable absence of the President, Dr. S. Rangachari, who came a little later Dr. M. S. Krishnamurti Iyer, one of the vice-presidents, took the chair.

1. The annual report for year 1930-31 was read and unanimously passed.

2. The following office-bearers were elected for the year 1931-32.

President.

Dr. S. Rangachari

Vice-presidents.

Dr. U. Rama Rao
„ M. S. Krishnamurthi Iyer

Secretaries.

Dr. C. R. Krishnaswami
„ Mrs. L. Jacob

Members of the Governing Body.

Dr. E. V. Srinivasan
„ T. Krishna Menon
„ K. Srinivasa Rao
„ T. Satakopan
„ V. D. Nimbkar
„ M. Subramania Iyer
„ U. Venkata Rao
„ U. K. L. Narayana Rao
„ G. Zachariah
„ M. Sanjiva Rao
„ Mrs. G. M. Thomas
„ Major M. R. Grandhi

3. There was a lively discussion regarding the change of hours of the meetings. While some were strongly in favour of the change of the time, others were rather averse after the days work to keep awake till 10 or 11 p.m. at night It was therefore suggested that a referendum be taken and the opinions of the members taken on the point.

4. The resolution of Dr. T. Satakopan proposing the change in name from " Union to **Association** " was unanimously passed.

BULLETIN
OF THE
SOUTH INDIAN MEDICAL UNION.

MAY, 1931

Modern Technique in the Treatment of Pulmonary Tuberculosis.

By Dr. S. Krishnaswamy, M.B., B.S.,
Hony. Asst. Physician, Government Tuberculosis Hospital, Madras.

Artificial Pneumothorax treatment.—It is generally recognised by those with experience of tuberculosis that the basis of treatment is rest of the diseased part. The spongy consistency and continual movement of the lung make it easy for tuberculosis to spread and it is not surprising therefore to see the rapid improvement which so often follows the induction of pneumothorax.

The principle of the treatment is to produce lymph stasis and to rest the lung, thus preventing the spread of the disease and allowing nature to effect a cure. We find in artificial pneumothorax one of the most valuable and effective weapons against pulmonary tuberculosis and at the same time it is very important to recognise its limitations.

Selection of cases.

A. In all unilateral cases of pulmonary tuberculosis pneumothorax should be considered if :—

(1) Constant rales are heard over some intercostal spaces with T. B. in sputum and the X-ray finding corroborate the same.

(2) The disease is acute. In this the danger of spread to the other lungs is so great that in any acute febrile case with definite signs confined to one lung it is safer to induce a pneumothorax.

(3) In spite of rest in bed, the activity persists or improvement is not satisfactory. This is the type of patient whose condition does not become stable and even the slightest exertion causes a rise in temperature or some other symptoms.

(4) The patient has to earn his living or for some reason is unable to undergo prolonged treatment. There is no doubt that with the affected lung collapsed, a patient is able to lead a more active life with much less ruin of a breakdown than one not so treated.

(5) There is repeated or severe hæmoptysis.

(6) There are cavities with copious sputum.

(7) There are certain complications such as tubercular laryngitis.

B. In bilateral cases, the indications for inducing artificial pneumothorax are affected by the following considerations :—

(1) If one lung is much worse than the other, collapse may remove so much of the toxæmia and cause so great an improvement in the patient's general condition that the disease in the better lung also improves, or a combination of pneumothorax and sanocrysin treatment is found to show greater improvement.

(2) On the other hand collapse of one lung may increase the activity in the other. This is especially the case when there is early bilateral disease.

In coming to a decision regarding the induction of artificial pneumothorax in a bilateral case, it is more important to consider the degree of activity than the actual amount of disease as

determined by physical signs in the better lung.

Contraindications for artificial pneumothorax are.—(1) In the absence of any of the special indications mentioned, pneumothorax should not be induced if the lesions are healing under ordinary treatment and the patient can afford the time to allow arrest ? to take place.

(2) When there is so much adherent plcura that it is possible to produce only a partial pneumothorax which is not sufficient to rest the diseased part. Sometimes a very partial collapse will have a beneficial effect on the disease but if it has no effect it is not advisable to continue it. It should be remembered that a satisfactory collapse is often obtained in spite of physical signs, X-ray appearance or even when a history of repeated attacks of pleurisy with or without effusion may suggest extensive adhesion. It should be never assumed that pneumothorax is impossible till the induction is actually met with failure.

(3) In very advanced cases, it is not advisable as it often adds to the patient's discomfort.

(4) Patients with a highly neurotic temperament do badly with pneumothorax.

(5) It is not indicated in cases where the tuberculosis of the lungs is a terminal phase of some intercurrent disease.

(6) Active bilateral disease is a contraindication only if collapse of one lung aggravates the disease in the other.

Apparatus.—In the tuberculosis hospital here, the apparatus devised by Drs. Lillingston and Pearson, is used as it is found to be very simple and satisfactory. It consists of 2 bottles A. & B. A is graduated from 0 to 1100 c. cm. Both are fitted with rubber stoppers. The Manomete, attached reads pressure in centimetres of water. When the apparatus is not in use the open ends of tubes are closed by sterilised glass rods. The apparatus is very simple. The bottles can easily be cleaned and the tubing boiled. Water coloured with blue ink is used for the liquid in the manometer.

Before using the apparatus it is important to see that there is no leak.

For the initial induction of pneumothorax a Riviere needle with a blunt end is used and is less likely to injure the visceral pleura than the pointed Sangman needle which is used for giving refills.

Choice of gas.—Air is always used not only because it is easy to get but because it approaches most nearly to the alveolar air and therefore less interchange of gas takes place in the pleural cavity.

Technique of inducing artificial pneumothorax.—The procedure should not be in the nature of a surgical operation and is better done in the patients' room. Of course all instrument should be boiled and the strictest precautions taken against sepsis.

Preliminaries.—The patient should be kept in bed for some days prior to the initial introduction of gas. He should be reassured beforehand that the puncture will be almost painless. The previous evening the patient is administered a mild purgative and an enema on the morning of the induction. The patient is not given any food. A few minutes before the initial operation, an injection of ¼ gr. morphine with or without atropine is given as a routine.

The patient should be arranged comfortably on the table supported by

pillows so that the site of puncture is uppermost and the ribs in that region are as far apart as possible. The spaces are percussed carefully and a spot of 5thhighest resonance is selected, usually or 6th interspace in the midaxillary line.

The area selected for puncture is there swabbed with Tr. Iodin; 3 to 6 c.c. of a 2% solution of novocaine is taken in a Roux Syringe. About 1 c.c. is first injected into the skin so that a small lump is formed and the skin anaesthetised. The hypodermic needle is then inserted into the middle of this lump and pushed slowly down between the ribs, novocaine being injected first and the needle is entered slowly till the pleura is reached and then removed. The Riviere needle is then fixed to the rubber tube after sterilization of the bends with absolute alcohol and sterilization of the rubber tube in the flame of the spirit lamp. The needle is pushed gently through the puncture in the anaesthetised area of skin till the pleura is reached. The trocar is then withdrawn, the tap at the top of the needle is turned off. The blunt end of the cannula is then gently pushed through the parietal pleura and when it is in the pleural cavity the manometer will show a negative pressure with oscillations corresponding to inspiration and expiration, which is recorded. This is initial pressure. At this stage the patient must keep absolutely quiet and the needle is held perfectly steady and the patient is specially warned not to cough. When from oscillations it is certain that the needle is between the visceral and parietal layers of pleura the clips are unfastened and about 50 c.c. of air allowed to be sucked into the pleural cavity. This is continued till 250 c.c. are given and the clip between the graduated bottle and manometer is closed and the fluctuations recorded. This is terminal pressure. The needle is then withdrawn and the puncture sealed with collodion which is kept in place by a plaster and the patient instructed to keep his hand firm on that while coughing, to avoid the air escaping into the skin and thus prevent surgical emphyseme. This precaution is taken only after the first induction.

Refills.—The first refill is given on the 3rd day using a Sangman needle instead of Reviere needle. No preliminaries are required. The morphine injection too is omitted. The spot selected is close to the previous one. 3000 c c. of air is usually given with a good minus pressure. Further refills are given on the 5th, 7th, 9th, etc., days, each day the quantity of air given being increased by 50 c.c. always taking care that the minus pressure is being maintained.

It is a mistake to leave too long an interval between the refills as this would result in the sufficient re-expansion of the lung to bring in contact the visceral and parietal pleura resulting in their becoming adherent in places. Firm adhesion may occur in 3 days or less and no amount of intrapleural pressure will separate the adherent surfaces. The process gradually spreads until the whole of the pleurae becomes adherent and the pneumothorax cavity obliterated in spite of maintaining higher intrapleural pressures. Sometimes one wants the lung to expand in this way and a process of gradual obliteration of the pneumothorax cavity with subsequent fibrosis is often a satisfactory termination of the treatment but if it is desired to maintain a pneumothorax, it is of the utmost importance to prevent the visceral and parietal pleura from coming into contact with each other.

Another common mistake is to maintain a wrong degree of collapse. Some patients do best with a very partial collapse and if this is increased, they begin to get thin, develop dyspnœa and

lose ground. Others fail to improve until a complete collapse is obtained and large and frequent refills are given. In the majority of cases, small refills are more suitable. In this hospital up to 1000 c.c. of air is given as maximum and this is kept up.

Another mistake is to leave too long an interval between refills in a patient where the gas is quickly absorbed. In such a case there is considerable re-expansion of lung between the refills and instead of keeping the lung at rest, it is alternately collapsed and expanded.

At the end of five refills, the patient's chest is X-rayed and the state of the collapse of the lung is determined, refills are regulated according to the rate of absorption of gas and the condition of the patient and it must be remembered that even in some individuals the intervals between refills and the correct quantity of air required vary as the treatment proceeds.

Adhesions may prevent a satisfactory collapse and lead to high intrapleural pressures, after only a small quantity of air has been given. If it is decided to go on with the treatment of *try-to-stretch* the adhesions, small frequent refills are better than large ones at longer intervals.

When fluid develops during pneumothorax treatment, the gas is less quickly absorbed and the weight of the effusion empties the alveoli completely of air, so that the lung is often collapsed for a long period without a refill, It is important to keep these cases under careful observation for adhesions are liable to form under the liquid and to draw on the base of the lung, thus starting a process of obliteration of the pneumothorax cavity. To prevent this, the fluid should be removed or replaced with air if there are any signs of re-expansion at the base of the lung.

Duration of treatment.—In a large number of cases the termination of the treatment is settled by various factors such as obliteration of the cavity by adherent pleura, development of active disease in the other lung, etc.

If, however, the patient is doing well and keeping free from symptoms and at work, the collapse should be maintained for three years and then the lung allowed to expand gradually.

Selective Collapse.—By this is meant the collapse of a part of the lung by artificial pneumothorax, the rext of the lung being prevented from collapsing on account of adhesions. Usually collapse tender to occur in the diseased rather than in the healthy parts of the lung. These are several difficulties in connection with this Firstly, success depends on a free pleura over the diseased area. Secondly, even if a selective collapse is obtained, it is very difficult to maintain it at the same amount, and even X-ray examination may be misleading, for the gas so often lies in front of or behind the lung instead of around it. Thirdly, the treatment is almost always affected by reactions following the refills Fourthly, the refills have to be small and frequent and therefore much time has to be expended on each individual case.

Nevertheless, a partial or selective collapse may be useful in bilateral cases.

Dangers of inducing artificial pneumothorax.—The actual dangers of inducing a pneumothorax under proper precautions are negligible but unfortunately two of them, *viz* , pleural shock and gas embolism, though both are extremely rare, are serious and often fatal.

Pleural shock —Only 3 to 4 instances have been experienced in this hospital ever since the pneumothorax treatment was started. This is the result of pleural irritation or puncture. The symptoms vary from a mere faintness to actual

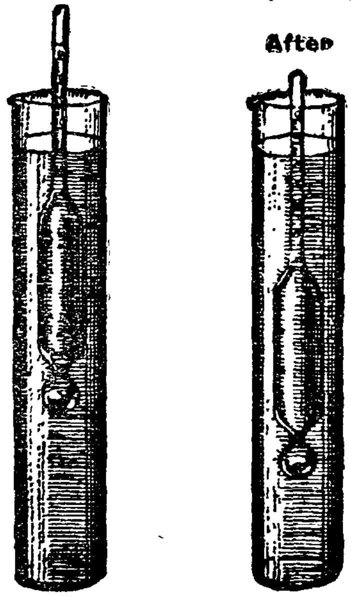
ELIMINATE

the risks of
Insulin Injections
by adopting

ORAL TREATMENT

with

PANCRÉPATINE



Reduces
the sugar in the urine
Prove it
by
HYDRO-
METER

A.F.D.

PANCRÉPATINE

FOR DIABETES

The Anglo-French Drug Co., (Eastern) Ltd.,

CHURCH GATE STREET, Post Box 460. YUSUF BUILDING, BOMBAY. Telegrams :—" AMPSALVAS, BOMBAY." Post Box 19, MADRAS.

SIROVASKA

THE IDEAL COUGH SYRUP.

A good **Expectorant & Antispasmodic,** quiets the irritable husky cough so often met with, soothes the bronchial tubes and is efficacious in **Coughs, Asthma** and all **Bronchial** and **Chest Affections.**

Contains no **Opium,** specially suitable for Children. An entirely Indian product made from Indian drugs.

Can be had of all Chemists or from :—

T. RAMACHANDRA RAO,

153, BROADWAY, **MADRAS.**

HEALTH RESORT

(A few yards from the Railway Station)

at Avadi near Madras

AN IDEAL PLACE

FOR REST AND RECREATION

PURE AIR & WATER, ELECTRIC LIGHTING AND ALL COMFORTS.

Apply to :—

Dr. A. Lakshmi Pathi, B.A., M.B. & C.M.,

Bhisagratna, Managing Director.

THE

MADRAS MEDICAL JOURNAL

(an illustrated quarterly)

IS THE ORGAN OF THE

MADRAS MEDICAL SERVICE.

AN ADVERTISEMENT IN IT WILL REACH EVERY MEMBER OF THE SERVICE.

For rates, etc., apply to :—

THE SECRETARY,

8, Luz Church Road,

MYLAPORE — MADRAS.

death and usually occur as the needle is entering or leaving the pleural cavity but they may come on during a refill or even some minutes after it is finished. It is said to be more common in the early stages of disease when the pleura is, healthy than in cases of advanced tuberculosis.

Symptoms.—The patient is suddenly collapsed. Pulse almost imperceptible. Breathing stertorous. Patient becomes livid and dies.

Gas Embolism.—I do not think that there has been even a single instance of this complication in the hospital statistics.

Other complications are puncture of lung, surgical emphysema, pain, dyspnoea, displacement of the medi-ostinumc, thickened pleura and pleurisy with or without effusion.

Of these, pleurisy with effusion is the most frequent complication of artificial pneumothorax. There may be no symptoms except slight pain, malaise and pyrexia. Occasionally, the temperature remains high and the patient's condition becomes steadily worse. In these cases it is found that the tuberculosis is spreading in the lungs and the development of the liquid seems to have been the starting point of a general breakdown. X-ray shows the presence of liquid beyond doubt and patient never be examined in the upright portion.

Pleural effusion is not a serious complication of collapse therapy and is often beneficial. The development of clear effusion doos not increase the mortality but when the fluid is purulent the outlook is much more serious.

The effusion usually develops in the first six months of treatment and after 12 months it is rare.

The treatment of pleural effusion complicating artificial pneumothorax depends on many factors and each case must be taken on its merits. If the fluid is left it will usually cause obliteration of the pneumorthorax cavity by pleural adherance and fibrosis starting at the bottom of the pleural cavity and working upwards Many cases of pneumothorax which terminate by obliteration in this way, do very well for, as the lung is drawn out, a satisfactory fibrosis develops over the diseased areas and the healthy parts of the lung begin to function once more.

If however it is decided to maintain the pneumothorax, the effusion must be aspirated and replaced by air to frevent obliteration of the pneumo thorax cavity. Usually after one or two aspirations the fluid does not reform.

In replacing fluid the quantity of gas required is less than that of the fluid removed.

If the fluid is purulent, the case is very much more serious. The pus should be aspirated and pressure kept as low as possible in order to help the lung to re-expand. If the lung does re-expand the outlook is hopeful and a satisfactory termination of the treatment by the obliteration of the pneumothorax cavity may be expected. If there is no sign of re-expansion the patient will probably have a permanent pneumothorax and be liable to any of the various complications of that condition. In such a case thoracoplasty should be performed as soon as possible, if not contraindicated by the condition of the other lung. The object of the operation is to close the pleural cavity and not to immobilise the lung as in other conditions.

Before leaving this subject, I have to state that a very important indication for artifical pneumothorax treatment is severe hæmoptysis coming from one lung. Especially in bilateral cases, where a patient may be doing fairly well on general lines of

treatment, and where he gets suddenly a severe attack of hæmoptysis from one lung, which is not amenable to any other form of treatment, artificial pneumothorax treatment has saved him miraculously from death. In these cases if the pressure allows, it is always advisable to give straightaway 400 to 500 c.c.

Phrenic Evulsion.—Section or evulsion of the phrenic nerve will cause paralysis of one half of the diaphragm and hence the movements of the lung controlled by the corresponding dome of diaphragm will cease. The operation is therefore useful for giving additional rest to the lung. The effect of the phrenic evulsion operation is that the paralysed hemi-diaphragm occupies a higher position in the thorax During ordinary respiration the paralysed dome of the diaphragm remains immobile. By the high and immobile position of the hemi-diaphragm the lung volume is said in favourable cases to be reduced not infrequently by one-quarter to one-third. The result of this reduction is a partial collapse of the lower lobe and a diminished respiratory activity especially at the base. The operation has the effect of partly immobilizing the lung and phrenic evulsion produces therefore an effect similar to that produced by artifical pneumothorax though to a less degree.

Indications.—The operation was originally performed chiefly as a preparatory operation to thoracoplasty with the object of testing the ability of the other lung to stand the strain of the increased respiratory work to be borne by it or with the object of giving the patient an opportunity of readjusting himself to the changes in the circulation and respiration resulting from the sudden collapse of one lung after thoracoplasty.

During last year phrenic evulsion has however gained much gtound as a substitute for pneumothorax treatment in cases where either pleural adhesions are preventing this treatment or where it is contraindicated on account of too extensive lesions in the less diseased lung. Generally specking, the indications for phrenic evulsion are the same as for pneumothorax treatment, although the indications can be extended also to cases unfit for pneumothorax treatment where for some reason or other, thoracoplasty is not advisable.

Several doctors consider that phrenic evulsion should be used as a substitute for pneumothorax treatment only in those cases where the lesion is confined to the basal part of the lung as the paralysis of the hemi-diaphragm could not have any effect on lesions in the apex of the lung. Others opine that good results have been obtained in cases with apical lesions on the ground that the upper part of the lung is unquestionably affected in certain cases which has been demonstrated by X-rays showing diminution in cavities near the apex following immediately a phrenic evulsion.

In the local Tuberculosis Hospital up to last year, this operation was performed only rarely and that too for cases of basal affection. It is only since the beginning of this year, this operation has become a routine treatment for cases where artificial pneumothorax has failed on account of adhesions as well as in some bilateral cases. It is yet too soon to say with certainty the actual results of the operation as it is necessary to watch the progress of the patients for some months, for the full benefit of phrenic evulsion can often be expected to be seen only after several months.

Technique of operation.—Under local anaesthesia with 1% solution of novocain with adrenalin, an incision from two to three inches in length is made over the posterior border of the sterno-mastoid muscle in the lower

third. The phrenic nerve is found on the anterior scalenus muscle beneath the fascia crossing the muscle from above downwards and outwards. When the nerve has been dissected totally free, it is divided after injecting a little novocaine into it. The visual end is caught by artery forceps and the nerve is made to wind round it a number of times by slow, steady and firm traction. The sure indication, that it is the nerve, is that on traction being applied to it the patient complains of severe pain over the lower part of that side of chest. After some inches of nerve ranging from six to more have been wound round the forceps the nerve snaps. After the nerve is removed, the incision is closed with sutures.

Dangers of the operation.—Though the operation is a minor one, it is not without risk. Severe hæmorrhage may result from the veins being cut. Secondly, the vagus nerve may be mistaken for the phrenic with fatal results. Thirdly, the traction on the nerve may rarely result in the rupture of the pleura.

Sanocrysin.—Preparations of gold have been used for many years in the treatment of pulmonary tuberculosis. At present sanocrysin is the form most commonly used. It is a double thiosulphate of gold and sodium which was prepared by Moellgard and was believed to destroy tubercle bacilli in vivo. It is given intravenously and is frequently followed by a severe reaction resembling that seen after an injection of tuberculin. At first it was thought that sanocrysin killed a large number of tubercle bacilli and that the reaction was due to the endotoxins set free in consequence. This view was supported by the undoubted fact that tubercle bacilli did disappear or become very scanty in the sputum after injections of sanocrysin.

An antitoxic serum was prepared and given before sanocrysin in order to counteract the reaction but it proved of very doubtful value and has now fallen into disuse. By decreasing the doses and lengthening the intervals between them these severe reactions were prevented. In the Tuberculosis Hospital here, up to last year, sanocrysin was started in doses of 10 centigrames and was increased by 5 centigrames once a fortnight till the complete course of 5 to 6 grs. were given. The doses were adjusted according to reaction. By this safe procedure, reactions were mostly avoided. Before sanocrysin was administered suitable cases were selected and the urine examined for albumin. Only in the absence of it, injections of sanocrysin were commenced. For three to four days after the injection the urine was examined for albumin. Even after such precautions, in three instances there was severe sanocrysin rash all over the body. This troublesome complication gave rise to much suffering on the part of the patients and lasted even for 2 to 3 months. It was on account of this suffering that sanocrysin treatment had to be stopped for some months. It has again been revived from the beginning of this year but in much smaller doses. The initial dose used is ·5 c.g. and increased by ·5 c.g. every week, when a dose of 30 c. gm. is reached the interval between injections is prolonged to two weeks. This routine is just under trial and it is too soon to say about the results.

Indications.—The acute pneumonic type of pulmonary tuberculosis is said to be best suited for sanocrysin treatment especially in its early stages.

In chronic tuberculosis of the lungs the following factors must be considered :—

(1) The extent and accessibility of diseased foci.

(2) The degree of resistance possessed by the patient.

(3) The state of efficiency of the eliminative mechanisms of the body.

Good results are obtained in exudative (caseous) cases of not more than 12 months' duration. In productive (fibrotic) type of cases of long standing with few or no blood vessels, it is obvious that the drug cannot penetrate through; hence these cases are not suitable for sanocrysin treatment.

Speaking in general terms, the advanced and tonic type of patient is unsuitable for sanocrysin treatment; while a relatively recent case, still well nourished and with some degree of control of his temperature, is likely to do well.

The chief indications for treatment may be grouped under four headings.

(1) To diminish the quantity of sputum and number of tubercle bacilli.

(2) To check an acute spread of disease.

(3) To treat a patient who is getting gradually worse under other treatment.

(4) To treat bilateral disease in combination with artificial pneumothorax.

Contra-indications.—(1) Slight and early limited lesions which can be cured by conservative methods. (2) Chronic fibroid lesions (3) Fever (4) Extensive disease of long duration (5) Renal and intestinal tuberculosis (6) Highly intoxicated cases having no power of resistance as indicated by failure to gain in weight when at rest, irregular temperature, high sedimentation rate, etc.

Complication.—(1) Febrile reactions which may be sudden and lasting but a few hours or which may be sudden but persisting for a few days or a long febrile reaction.

(2) Albuminuria (usual complication) Treatment is stopped till this disappears and then recommenced with smaller doses.

(3) Gastro-intestinal symptoms such as vomiting, looseness of bowels, mild stomatitis.

(4) Aching in the limbs and rheumatic pains.

(5) An erythematous rash especially in a severe form may occur. In these cases the rash went on to a desquamative dermatitis. Treatment should be stopped once for all.

Results of Treatment.—The most striking change is the diminution in the quantity of sputum and tubercle bacilli in patients with chronic pulmonary tuberculosis.

(2) In acute cases sanocrysin often fails to produce any effect whatsoever but sometimes will check the spread of the disease.

(3) Sanocrysin should be regarded as a drug which in certain cases aids other methods of treatment. It is not a cure and is never more than part of the treatment.

(4) The dangers and complications of sanocrysin treatment are not great, provided dosage is carefully regulated.

I now propose to show you a few skiagrams and case reports demonstrating the efficacy of artificial pneumothorax and other treatment.

In conclusion I have to thank Dr. Kesava Pai for having allowed me to make use of the hospital material for my lecture.

REFERENCES.

1. Recent advances in Pulmonary Tuberculosis, Burrell.

2. Pneumothorax and Surgical Treatment of Pulmonary Tuberculosis, Clive Riviere.

3. Modern Methods in the diagnosis and treatment of Pulmonary Tuberculosis, Ringfield.

4. Phrenic—Exairesis, Frimodt-Muller and Gnanamuthu, Indian Medical Gazette, March 1930.

5. Use of Sanocrysin in Tuberculosis, Shrikhande, Indian Medical Gazette, February 1928.

The Successful Medical Practitioner*

By Dr. U. D. Gopal Rao,

Madras.

Mr. President and gentlemen,—Excuse me for the subject of this evening which to a certain extent breaks the usual routine of hearing scientific lectures delivered by eminent doctors, and deals with some problems of practical importance to the independent medical men. Apart from subjects of great clinical interest it is not uncommon for any medical association in the world to indulge in topics of professional interest and business importance. "The doctor and his investments, My clinic, Shall the specialist hide his light?, Hospitals can be human, What is practice worth?, What is the average fee?, Past dues, What makes the doctor a poor credit risk", have been some of the subjects of business character and economic value successfully handled and proved to be of practical benefit to the medical profession in America. Hence it will not be out of place or uninteresting if the members of the South Indian Medical Union, were to deliberate on subjects of economic value in the practice of medicine. How shall I be a successful medical practitioner, The pitfalls in independent practice, Professional fees, Prevention of bad debts, are some of the problems which you and I are not unaware of—how want of better understanding and co-operation trouble our minds and give room for keen professional anxiety and hinder the building up of a successful practice. Confining myself to the lot of the independent medical man, practising with a poor start and entirely standing on his own legs for his future progress, you cannot forget the day when you sat in your consulting room and observing not a single patient entering your door began questioning yourself "How shall I be a successful practitioner," nor can you forget the incidents when patients higgle over your charges, worry you by putting off payments for an indefinite period and worse still leave you on legal pressure.

*Paper read before the South Indian Medical Union.

With these preliminary reasons in support of my selection of the subject of this evening, I venture to put forward my views about "The successful medical practitioner" and earnestly hope better experienced gentlemen assembled in this hall will throw light on the subject for the benefit of the younger men.

The success or failure in any profession, legal, engineering, educational, commercial, etc., depends on the individual strength of mind, the fund of knowledge and the skill, tact or ingenuity to grasp the public need and act with a spirit of self-sacrifice. More so the success of the medical profession which has been universally regarded as the noblest of all professions not only depend, why must depend, on the individual character, intelligence, and spirit of sacrifice of the young man who has the good fortune to be called a 'doctor.' Hence it will not be an exaggeration if I were to describe the successful medical practitioner as one who possesses a strong moral character, who is always kind and sympathetic, sound in knowledge, yielding to what is reasonable and alive to the call of duty even at great sacrifice.

Essential qualities for successful practice.—1. *Popularity*—The royal road leading to successful practice is not within the easy reach of any and every medical man. There are certain obstacles in the way that require careful and deliberate handling. Temptations are many; here are some rich patients asking for a medical certificate to hide some criminal offence; again there are gosha patients who want their pulse felt over a silken cloth and

the chest piece of the stethoscope kept only on the infra or supra scapular regions covered by jackets, there again a group suffering from diseases of a virulent type unable to take to the independent medical service for fear of cost, and unwilling to go in for the hospital aid, fall at your feet, with very little remuneration, that too perhaps borrowed by a pledge of the wives' bangles or necklace. It is here in independent practice one should show the strength of character to with-stand temptations and patience in the troubles due to illiteracy of the suffering public. These are the opportunities which almost every medical man is fated to meet to show his love for humanity and sympathy to the suffering. It is the weapon by which one can easily remove all barriers to successful practice. Any number of degrees, any amount of influence or any display of show will not qualify one to be a "popular doctor." Time, experience, suffering and sacrifice only will win this.

2. *Public Confidence.*—A careful study of the clinical picture of the case in hand, a thorough perception of the circumstances of the patient, an intelligent outlook to apply the principle of differential diagnosis and the most peculiar knack, skill or instinct, call it whatever you like, to understand the wants of the patient and give him immediate relief are some of the virtues of the medical man which would help him much to gain the confidence of the patient. Gentlemen present here are not unaware how a judicial use of the pituitrin needle, in a case of delayed labour, p. p. h. or pneumonia crisis, adrenalin in asthma, morphia in certain acute conditions, a timely incision in an acutely inflamed piles or an ischio-rectal abscess, a dose pyramidon for an intense headache bring on immediate relief and immense satisfaction to the patient, and gratitude towards to the medical attendant. It is this first impression on which the success or failure of the doctor depend. Just as a surgeon's skill in an operation is judged by the first line of incision so the patient understands his medical attendant by the first results. When once the public confidence is gained there starts the good star for successful practice. Patients increase and consult for any and every disease wherever he may be. One cannot dismiss him by an occasional loss of temper or heavy charge. The doctor will be regarded as the second God on earth.

The different stages of private practice.—Stretching our imagination to the lives of other professions in the world, legal, engineering, etc., it is easily observed that there is some natural phenomena which is more or less responsible for the growth or decay of these professions. The workings of this phenomenon are marvellous. Just as the human life passing through different periods of growth, the infancy, boyhood, adult life and middle and old age meets with natural barriers of disease and death, so also the professional life cannot meet with success unless it passes through certain periods of fall and progress. Instances are few where you can find a regular enteric rise of progress throughout the professional period. There should be the 2nd week full and rise a period of professional anxiety and encouragement. The complications of the 3rd week cannot be forgotten or avoided, professional pitfalls are many and opportunities are few. A steady growth could be maintained and chances of success are greater when once the complications are met with proper care and diet. The pitfalls should be met by proper patience and perseverance. The period of convalescence is the period of successful practice. Professional anxiety is at an end, self-confidence sets in and a faith is created, that the period will be a successful one. Hence it is no wonder the independent medical practitioner if

The normal functioning of sexuality

is dependent on the co-operative action of the blood glands

If one desires to restore the harmony of the hormones it does not suffice to supply the substances of the generative-glands only. The juices of the other blood-glands must also be added.

Testogan and Thelygan

FOR MEN — FOR WOMEN

are the first combined gland preparations

The sphere of employment for both preparations may be summed up as follows:

Deficient sexual and other bodily development, acquired and premature sexual debility and want of sensitiveness with all their results, certain kinds of sterility, general conditions of exhaustion and low spiritedness, poor bloodedness, disturbances during the climacteric period, menstrual disturbances, premature agedness.

Packings of 40 and 100 dragées and 12 ampoules.

D R. G E O R G H E N N I N G / B E R L I N

Literature and full particulars from the Sole Agents:

VOLKART BROTHERS,

Bombay, Calcutta, Madras, Karachi, Colombo.

NEOTROPIN

A urinary antiseptic of remarkable powers of penetration and tissue affinity highly bactericidal

NEOTROPIN is a dye-stuff of the azo-pyridine series and possesses the marked powers of penetration and tissue affinity inherent to dyes. Shortly after its administration it imparts a yellowish red colour to the urine and later the prostatic, testicular and cervical secretions.

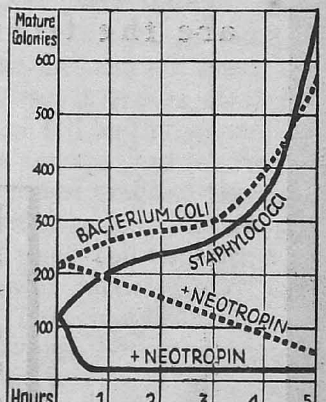
The bactericidal effects of Neotropin have been confirmed by a long series of experiments both in vitro and in vivo. Even in a dilution of 1/512,000 it still inhibits bacterial growth.

Its combined penetrative and antiseptic properties render it invaluable in the treatment of Bacteriuria, Cystitis, Pyelitis and Pyelonephritis.

Its freedom from any irritant effect explains its remarkable efficacy in acute gonorrhoea and cystitis.

Original Packing:

Bottles of 30 dragées of 1.5 grains.



The curves show the increase in growth of bacteria in ordinary urine compared with the decrease in growth produced by Neotropin

SCHERING-KAHLBAUM (INDIA) LTD.

P.O. BOX 2006, 4, DALHOUSIE SQUARE, EAST, CALCUTTA

Head Office :—CALCUTTA.

Branches :

Bombay, P. O. Box 683.
Madras, P. O. Box 1215.

'Grams : AESKULAP.

Agencies :

Karachi, P. O. Box 54.
Lahore, 136, Anarkali.
Rangoon, P. O. Box 1025.

he desires to achieve his end must pass through certain periods during which he gains experience and self-confidence. Broadly speaking these periods can be classified under two heads—a period of study of practice, a period of steady or successful practice.

A study of practice.—For the convenience of the subject this can be lengthened to 10 years' duration when the medical man undergoes a thorough training in the business aspect of his practice to be described hereafter and will be in a sound position to launch on the second glorious period of successful practice.

The various problems that are to be considered from a business point of view can be classified under several headings.

1. *The earnings*—Excuse me gentlemen, if I were to opine that every budding doctor engaged in private practice must pass through a certain period of starvation. He cannot help it. There will be some days when you get nothing and at the end of the month the bank balance is more towards the debit than credit side. Because the income is less the expenses cannot be curtailed.

2. *The field of practice*—This is most unfertile for the beginner. All healthy soils have already been exploited by the good old senior practitioners belonging to his own group and others of the native medicine, the pandit, the hakim, etc. Practice depends entirely on chance and chance alone. A case already under the treatment of another doctor, suddenly develop into one of convulsive fits, or hyperpyrexia at dead of night when the usual medical attendant is absent and the people anxious about the case want some doctor who could give relief and by chance knock at your door. Your ready response to the call and sympathetic treatment of the case will create a sort of confidence which helps for future calls. If not for calls it makes the people know that there is a doctor who attends cases at nights too. Again a case of accidental injury, drowning, burn, scorpion bites, ear ache, eye catarrh, foreign body, a phimosis, a bubo are some of the cases which a beginner gets in early practice. Yet another group, the habitual professional dodgers who always hunt after new doctors for the convenience of easy credit, also chance to fall at the beginner. Very few family patients, rarely an educated gentleman, some from the middle and poor classes or a student form the only field of practice at this stage.

3. *Administration of Drugs.*—A careful study of psycho and idiosyncracy is very essential for private practice. Heroic doses of aspirin, chloral hydras and opiates should be avoided. Careless administration of iodides and mercurials without sufficient prewarning will surely bring the black mark of "a poisoner" from the illiterate class. Gentlemen present here are not unaware how at time the intravenous administration of quinine, ureastibamine, and salvarsan result in very grave conditions causing anxiety and embarrassment. With senior people it is alright but for the beginner it is something like treating a case of pneumonia successfully for the first seven days and leaving the crisis stage uncared for and to consequent fatality. Once to the knowledge of the speaker an eminent doctor of the city of Madras prescribed ¼ grain dose of a calomel with hyoscyamus to relieve an acute abdomen due to liver disorder in an adult. An hour had hardly passed when signs and symptoms of mercurial poisoning were noticed. Besides the swelling of the buccal membranes, the gums, the salivary glands the epiglottis and the oesophagus and the consequent difficulty of taking in a drop of fluid the so-called poisonous dose of calomel ¼ grain, inflamed the

intestinal canal brought on dysenteric stools as if the patient was acutely infected with amoeba. It took nearly 20 days for the patient to get alright, and the patient has been displeased.

4. *The Equipment.*—Needless to mention, a medical man well equipped and professionally will command generous practice everywhere. He should be sufficiently minded to do careful clinical research. The investments made on some of the more modern diagnostic appliances as a microscope, sp-mano-meter, and some other bacteriological requisites will be helpful for our clinical work.

5. *Consultations.*—What is in vogue cannot be avoided. There is no hard and fast rule that a patient must pay the consulting fees. Generally in this city it has been free. But very great discretion is needed in welcoming patients into consulting rooms. There are people who taking advantage of a new doctor's board in the street, slowly step in, talk nicely about the doctor, praise him to the skies, encourage him that they would be his best friends and introduce patients, get themselves examined thoroughly for half an hour and slowly walk away saying that he would come afterwards for the medicine. Examples are not wanting where some patients come and tell so many tales against other medical men, give a long history of his case and request an examination with a promise to pay afterwards which they will not keep up. All these are unavoidable and one cannot be wise in this period. Skill and tact should guide us in such instances.

6. *Professional and other charges.*—This is the most difficult and trying problem for the practitioner to solve during this period. Unaccustomed to ask point blank the fees, inexperienced to charge how much, unable to distinguish the poor and the rich, ignorant of the business side of working out the profit and loss it is not uncommon that many a budding doctor bungles to make a fair professional charge. To understand a man worth lakhs coming under the garb of a stingy beggar higgling for 12 annas quinine mixture but paying in fifties and hundreds when given an apparently bad prognosis of the case, or an exaggeration of the sheetala or janni pulse as commonly understood in a case of gastro-intestinal catarrh or hyperpyrexia; to believe the truth of the statements of some of the well to do classes, that their circumstances would not permit to meet a doctor's bill a visit and plead proverty and get the fees reduced, but find them at the next moment in a den of shame or a public tavern is no easy job for the beginner. Time and experience only will solve these things. But yet the noble principle of moderation, the silken thread running through pearls of virtues should be the guiding factor in making professional charges.

7. *Collection Tactics.*—This is another difficult problem to be met with. With a view to get patients and increase the business a free allowance of credit account is not uncommon with a raw medical graduate. Except the very few who realise the services of the doctor and pay bills regularly, many disappoint by irregular or non payment. Worse still they turn against the medical man stating the charges are high and cure was not given. Legal pressure in such cases not only result in extra expense and trouble but very great unpopularity. Under the circumstances when there are heavy bills to be collected, some plans which many of the American medical organisations have adopting will not be out of place here.

Just after the routine despatch of the monthly bill if no payment is made reminders are sent in the following order giving each memo a personal touch.

Dear Sir, I beg to invite your attention to my bill Rs......which remains outstanding for a considerable length

of time. As I have not been favoured with any remittance in spite of several reminders I shall feel obliged if you give this matter your immediate attention and send me a cheque in full settlement at your early convenience. Yours faithfully,

If by the end of a fortnight no reply or payment is received, a 2nd reminder follows.

Dear Mr. X, My bill collector tells me that for some reason you have not paid your account nor have you replied to the courteous notice sent you. I feel sure that if there is any misunderstanding it can be removed by a moments conversation and I am not willing to let a cause of trouble come between you and me when it can be so easily prevented. Will you please call me when you get this memo and make an appointment with me? Cordially yours.

If there is no proper response to this reminder, a 3rd letter follows.

Dear Mr. X, If ? were to fall sick to night would you refuse to call me? I won't believe you would and I surely hope you would not. But sometimes when a man owes a bill which is long overdue he hesitates to seek the aid of that creditor because failure to pay stands in the way. You know I would come to your aid and give the best service in me even if you never paid me a pie. And I believe you and I are close enough friends to prevent you from taking offence at this letter. If I am right wont you send me a cheque for a part of the amount you owe me? Or if I am wrong come to-morrow and we will talk it over. Faithfully yours.

Some of these personal letters will have a very great effect on the patient and payments are readily made.

It is an essential to the business quality not to incur the displeasure of the client. Lot of patience and perseverance are required to make collections easy.

8. *Superstitions in practice.*— Medical men both in the mofussil and the metropolis are not unaware how superstitious ideas play a great part on the public mind in curing or exacerbating diseases. The new moon days, the barani and krithigai stars, rahu and guli kalams for the Hindus, Thursdays and Fridays for the Mohammadans and Sundays for Christians are inauspicious days for medical consultations. Dashing a bunch of leaves against the bed side of the patient by a mantravadi and smearing the body with the holy ash (vibooti) in a case of malarial rigor, convulsions or hyperpyrexia are regarded as the basis of the general prescription for the child and the doctor's quinine mixture and the sedative dose are only adjuncts. The superstitious belief in the family vaidyan is so great that in many cases of pyrexia the *kolandai vaidyan's* kasturi or the croton pill precede the laxative and the diaphoretic mixture of the medical attendant. Deliberation in suggesting ice application in a Mohammadan house, soap and water enema in an illiterate Hindu house and prescribing whey or other lemon preparations as diet are very important. These prescriptions are usually received with a reluctant mind and if anything serious were to happen it will be attributed to this prescription. The medical man should neither forget the apparent understanding of the shetala, pitta, kaffa, janni pulse in all cases of influenza, pneumonia, typhoid, cholera, eclampsia, etc. The yellow cloth round the wrist, the holy ash on the forehead, the red water plate at the corner of the sick room, the crowd round the patient rubbing the extremities are sufficient bad prognostic signs which superstitions warn and the doctor will do well to retire.

Second period of steady practice.— The above are some of the problems which a medical man should meet during the first years of his practice. Once this stage is passed and the obstacles overcome he lands on a more healthy atmosphere where he can be

proud of a standing practice. The circle of practice becomes larger and larger, the good old name spreads slowly and steadily into four corners of the city, the bank balance always stands at credit side, professional anxiety gradually becomes lesser and lesser and by the time he spends the period, say about 10 years he gains self confidence, that he could get on without any room for anxiety or trouble. This is the period in which ideas of public work predominate in the mind. The so-called professional dodgers cannot dupe him, the art of studying the patients is complete, he knows whom to charge and whom not to charge, credit collections will assume the shape of a regular monthly salary, the consulting hours become more and more regular, the mutual confidence between the patient and the doctor is increased and a sense of self-confidence firmly develops into one of steady successful practice.

General Observations—Medical Ethics.—Ignorant of the *a*, *b*, *c* of medical ethics, inefficient to put into practice the golden rules of medical morality and unadvised to follow the royal road of decent practice, it is not uncommon that many a doctor, more in the first than in the second period, give room for a clash with a co-professional in private practice. The only sedative dose to minimise these occasional rubs is real understanding of the nobility of the profession and the large hearted policy of the medical man of the second period.

The duty of the Government.—However much the independent medical man strives to do successful practice by gaining popularity and public confidence, however much the young private doctor attempts to give a successful cure in a complicated case by an up-to-date knowledge of things gained by experience and study his labours are often met with a certain contempt from the public owing the existence of the caste system in the profession for which the Government of the country is responsible. The popular impression of small and big doctors as commonly applied to an I.M.S., M.B. & L.M.P. is a degradation to the medical profession as a whole and a hindrance to successful practice for the particular groups in particular. This caste system is alright in a hospital where administration is on the principle of inferior grades and the person held responsible is always the superior with the highest qualifications. In private practice this does not hold good. Disqualification and deficient knowledge may result in serious loss to life by quackery or improper treatment. It is high time for the benign Government to remove this caste system in medicine and impart the highest training possible for the medical man in the interest of the public health.

REVIEW.

Medical Review.

We have received the first number of this new magazine issued under the auspices of the medical practitioners of Northern India. It is conducted by a strong editorial board and from the numerous letters of approbation and support it has received, should go a long way in removing the disabilities under which the medical profession especially the Independent Medical Profession, work in that area. We wish the magazine every success.

Syr Siro Vasaka.

We have received a sample of the above. It claims to be an effective remedy for common colds and minor respiratory disorders. The composition is given and the components are reputed ayurvedic and allopathic drugs. In these days of national revival, it would be of great help if more remedies of indigenous origin are placed on the market. Syr Siro Vasaka is palatable to the taste and declared free from dangerous ingredients.